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Applicability:	DDSN Regional Centers, DDSN Service Providers of: Residential Habilitation, Day Activity, Career Prep, Community Services, Employment and Support Center Services

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Purpose

This procedural directive establishes a standardized definition and reporting system for medication errors/events in order to improve the health and safety of DDSN consumers. Medication errors/events may occur in DDSN Regional Centers or when the following services are being provided to DDSN consumers - Residential Habilitation, Day Activity, Career Prep, Community Services, Employment and Support Center Services.

General

The South Carolina Department of Disabilities and Special Needs (DDSN) recognizes that medication errors represent one of the largest categories of treatment-caused risks to consumers. As a result of this, every ~~agency~~ organization that provides services and supports to ~~people~~ individuals who are medically involved should have a medication error/incident reporting, analyzing, and follow up capability, as part of their overall risk management program.

The safe administration of medication is an important part of the overall health care program provided by DDSN and its network of service providers. Safe medication administration requires training, experience, and concentration on the part of the ~~person~~ individual administrating the medication. For this reason, medication administration should occur in an orderly environment and at a time when those administrating medications are not distracted with other tasks. The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) has urged agencies, institutions, and researchers to utilize this standard definition of medication errors. DDSN has adopted this definition. (For more information on NCC MERP, see www.nccmerp.org)

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use." In addition, DDSN recognizes that family situations and pharmacy errors may contribute to medication errors/events.

Types of Medication Errors/Events

According to the above definition, there are some kinds of medication errors that are outside the control of DDSN and its network of service providers (e.g., naming; compounding; packaging etc.). If provider ~~agency~~ organization staff discovers errors of this type, the pharmacist should be notified immediately in order for corrective action to occur. The types of medication errors/events that are within the direct control of DDSN and its network of service providers, and therefore of most interest, can be divided into three (3) categories:

1) bona fide or "true" medication errors;

2) transcription and documentation errors; and

3) "red flag" events.

1) MEDICATION ERRORS

- Wrong person given a medication
- Wrong medication given
- Wrong dosage given
- Wrong route of administration
- Wrong time
- Medication not given by staff (i.e. omission)
- Medication given without a prescriber's order

2) TRANSCRIPTION & DOCUMENTATION ERROR

- Transcription error (i.e., from prescriber's order to label, or from label to the Medication Administration Record (MAR)

- Medication not documented (i.e., not signed off)

- Medical Observation/Pre-Treatment Requirements included on the MAR are not documented as completed. The documentation error/omission is related to a specific observation/pre-treatment prescribed for collecting data to monitor medication effects. Observation/pre-treatment that is not specifically prescribed and included on the MAR would not be a documentation error, but rather, a red flag event.

3) RED FLAG EVENTS

- Person refuses medication (this event should prompt the organization to make every effort to determine why the person refused the medication. Specific action taken should be documented. Each organization must develop a reporting system for these events)

- "Near Misses" (i.e., medication error almost occurred)

- Unsafe circumstances (i.e., that may lead to a medication error in the future)

- Discarded medication found (i.e., on the floor, bureau, etc. Internal investigation must be conducted to determine the intended use of the discarded medication to insure this event would not lead to a medication error)

- Medical Observation/Pre-Treatment Requirements related to the person's use of a particular medication is not documented as completed according to the Plan (i.e., Blood Pressure Checks, Blood Glucose Monitoring, Weight Checks, Skin Checks). Red Flag events include documentation errors (or omission) that are not to be recorded on the MAR, but on a separate documentation form, as specified in the person's plan.

Data Collection

In addition to providing a standardized definition of medication errors, NCC MERP has developed criteria to guide the development of databases used to record, track and analyze medication errors or other "red flag" events associated with the administration of medication (i.e. the "Taxonomy of Medication Errors"). These criteria help to determine what information to collect when a medication error or "red flag" event occurs.

DDSN has followed the general guidelines of the NCC MERP "Taxonomy of Medication Errors" in developing the attached Medication Error/Event Report Form. DDSN Service Providers will be required to develop their own data collection system to track, monitor and analyze medication errors/events. This includes the process of medication delivery and all components of the MAR. Medication error rates and their corresponding data must be made available to Quality Assurance Review and Licensing Review contractors and DDSN staff upon request.

Proactive Analysis

In order to be consistent with "best practice", medication error reduction efforts should possess the capability for both reactive and proactive analysis. Reactive analyses include efforts to better understand both a specific medication error that has occurred and the analysis of aggregate medication error data. Methods of proactive analysis, on the other hand, include the analyzing of consumer refusals, "near misses" or other unsafe circumstances that may lead to a medication error in the future, and the analysis of errors that have occurred in other systems or settings. Providers are required to categorize the types of errors/events reported in their analysis. NCC MERP has indicated "the value of medication error reports and other data gathering strategies is to provide the information that allows an organization to identify weaknesses in its medication use system and to apply lessons learned to improve the system. The sheer number of error reports is less important than the quality of the information collected in the reports, the health care organization's analysis of the information, and its actions to improve the system to prevent harm to patients."

For each service location where medications are given, providers are required to record the monthly error rate expressed as a whole number with three decimal points (number of errors divided by the total number of medications passed for each calendar month) along with the number of errors/events. Error rates are not to be used as a substitute for the actual number of errors/events. For clarification, medications passed will include ALL medications: oral, injections, topical, drops, and breathing treatments. The Consulting Pharmacy can usually provide this information for providers. This monthly error rate calculation will allow providers to incorporate data from individual locations into their Risk Management data to identify trends and work with specific areas to determine the need for more assistance and/or training. Both Medication Errors and Documentation Errors are to be included in the Error Rate Calculation, but providers may choose to document as two separate rates. "Red Flag Events," such as refusals or "near misses," would not be included in the error rates, but there must be a medication error form completed to ensure appropriate follow-up.

Reporting Procedure

The first person finding the medication error/event is responsible to report the error or event to supervisory/administrative staff, such as the employee's supervisor, program director, nurse in charge or Executive Director/Facility Administrator. The immediacy of the error reporting is dependent on the severity of the incident or the organization's internal policy. Depending on the type of error/event, the supervisor/administrative staff shall use professional judgment regarding whether a call to the prescriber is indicated. The supervisor/administrator may also determine that a "911" call is needed.

1) If the prescriber is contacted, the supervisor/administrator will follow the prescriber's orders, if given, and ensure the orders are well documented, including the name of the prescriber consulted. Only a nurse can take a verbal or telephone order from a prescriber, and the new order should be written on the medical orders sheet with supporting documentation in the Nursing Notes.

2) The person should be observed and monitored for any adverse reactions. These may include changes in behavior, levels of alertness, changes in vital signs, or other physiological responses.

3) Document all findings in the Nursing/Medical Section Notes and follow up with the prescriber as needed. This would include a review of the frequency of the type of error/ event, including red flag events, and monitoring of any corrective action needed.

4) Medication errors/events that are the result of pharmacy errors should be reported to the pharmacist for immediate corrective action.

5) A medication error/event resulting in serious adverse reactions must be considered a critical incident and have a critical incident report filled out (100-09-DD).

6) As soon as possible, the person finding the error or identifying the event completes the Medication Error/Event Report form (see attached) and submits it to the supervisor/administrator (or other "in charge" person who is on duty).

7) Upon receipt of the report, the supervisor/administrative staff reviews it for accuracy, signs and forwards the report to the Director of Nursing, Nurse Consultant, or designee.

8) If the medication error/event resulted in serious adverse reactions, and was thus considered a critical incident, then the supervisor/administrative staff will notify the Executive Director, Facility Administrator, or designee.

9) The Director of Nursing, Executive Director, Facility Administrator, or designee will assure that all medication events are entered into the provider's medication error data collection system and will assure this data is available to the quality assurance and risk management staff/team for analysis, trend identification, and follow-up activity as needed.

10) DDSN may request all data related to medication error/event reporting at any time or during any of the Service Provider's annual reviews.

Follow-up Activities

The purpose of recording and analyzing medication errors is to create a safer, healthier environment in which DDSN consumers live and work. If medication errors are recorded and analyzed, but no follow-up activities are implemented, then the purpose of the effort has not been achieved.

At the provider level, reactive and proactive analysis of trends should be coupled with appropriate corrective actions. These actions may include, but are not limited to, additional training (including medication technician certification), changes in procedure, securing additional technical assistance from a consulting pharmacist, and improving levels of supervision.

Each provider should adopt a method for documenting follow-up activities such as utilizing memoranda or the minutes of risk management/quality assurance meetings. This information must be included as part of the data collection system related to medication error/event reporting.

Susan Kreh Beck, Ed.S., NCSP Associate State Director-Policy (Originator)	Beverly H. Buscemi, Ph.D. State Director (Approver)

Related Policies:

100-09-DD; 100-26-DD

To access the following attachments, please see the agency website page "Attachments to Directives" under this directive number at http://www.ddsn.sc.gov/about/directives-standards/Pages/AttachmentstoDirectives.aspx.

Attachment: DDSN Medication Error/Event Report